

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19576

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Firman DesLoge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community years, months or days)

3. (a) PRINT  
FULL NAME

Fox, Anna

3. (b) If veteran,

name war No

3. (c) Social Security

No No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William C. Fox 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. 27, 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 4 24 hr. min.

9. Birthplace Philadelphia Penn.  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

12. Name Geo. Wallace  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know  
15. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Geo. S. Fox  
(b) Address 3157 Portis Pl.

17. (a) Cremation (b) Date thereof June 23, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory  
Weick Bros.

18. (a) Signature of funeral director 2201 S. Grand Bl.  
(b) Address

19. (a) JUN 23 (b) J. F. Bradish  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0013  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3157 Portis Place.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 21  
year 43 hour 9:00 minute A.M.

21. I hereby certify that I attended the deceased from 6-19-43  
19 6-21, 19 43

that I last saw her alive on 6-21, 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Occlusion 5 min  
Duration

Due to Sclerosis of coronary arteries ?

Due to 94

Other conditions Congestion of lungs, liver, spleen  
(Include pregnancy within 3 months of death)

Major findings: Hypertrophy of Heart - Old Infarct - left  
Of operations Ventricle - mural thrombi - left ventricle

Of autopsy Same as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature G. D. Brown (M. D. or other)

Address 1325 S. Grand Date signed 6/21/43

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Samuel A. Stewart*

Licensed Embalmer No. **3722**.....

P. O. Address **412 Duchouquette St.**.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**